

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2026
NAME OF PROVIDER OR SUPPLIER Crossview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 402 E. Bay St Pineview, GA 31071	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility policy titled Freedom of Abuse, Abuse Prevention: Fast Alerts, the facility failed to ensure that one of 18 sample residents (R) (R10) was free from misappropriation of trust account money. Findings include: Review of the facility policy titled Freedom of Abuse, Abuse Prevention: Fast Alert dated January 2025 documented Misappropriation of Resident Property as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. Review of the electronic medical record (EMR) revealed R10 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, mild intellectual disabilities, brief psychotic disorder, paranoid personality disorder, and seizures. Review of R10's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's Brief Interview for Mental Status (BIMS) score was 09, indicating the resident's cognition was moderately impaired. Review of the Resident Fund Management Service form dated 03/26/2021 revealed the resident had a transferring (automatic transfer of care cost payments due to the facility) resident fund account set up with the facility. Review of the Facility Incident Report Form dated 02/06/2026 revealed the facility reported Exploitation/Misappropriation of Resident Property/Funds. The report indicated the resident did not authorize an online purchase for clothing on 11/25/2025. The resident reported to the [NAME] President of Operations on 02/06/2026 that he was unaware of the purchase and did not have knowledge of funds in his Resident Funds Management System. Review of the facility investigation and the undated follow-up report indicated that on 02/06/2026, a facility employee reported the incident to the [NAME] President of Operations and an investigation was initiated. Review of the 02/05/2026 written statement by Licensed Practical Nurse (LPN) A revealed that around Christmas 2025, they received jumpsuits for residents on the [NAME] Wing. LPN A noted she had heard other staff voice concerns that the jumpsuits were paid for out of R11's personal funds. She further noted that on 02/04/2026, she went to the copy machine and noticed a receipt with the resident's name on it and an order in his name for jumpsuits totaling almost \$5,000. The last page had an X as his mark and the previous Administrator's and receptionist's names. She noted she knew the resident would not be able to make an X that well. LPN A immediately notified the Regional Operations Manager and reported that other staff had told her the previous Administrator and former receptionist instructed staff not to tell the resident he had a substantial amount of money in his account. The [NAME] President of Operations interviewed the resident, who indicated he was not aware of the purchase, nor did he authorize the purchase of clothing items totaling \$4,899.05. The previous Administrator and previous receptionist both signed and witnessed the invoice alleging the resident authorized the purchase. Both employees were placed on suspension pending investigation. The [NAME] President of Operations reviewed the invoices, validating the purchase of clothing in the amount of \$4,899.05. The items were delivered to the facility, and the invoice had a mark indicated by the Administrator as being given by the resident authorizing the purchase. The resident stated he did not make the mark, or if he did, he was not aware of what it was for. A check in the amount of \$4,899.05 was deposited into the resident's account to reimburse him. The Administrator and the receptionist were terminated from (continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>employment for not following policies for Resident Trust Funds. Review of the 11/25/2025 invoice from Resident Essentials revealed a total amount of \$4,899.05 was spent purchasing 63 articles of clothing ranging in size from medium to 3X. Further review of the invoice revealed a perfectly marked X with the witnesses being the previous Administrator and the previous receptionist. Review of additional documents, such as a Check Cashing Authorization form dated 04/07/2026 and the Resident Shopping List/Spending Report signed/marked by the resident dated 03/04/2026, revealed the X mark made by the resident had very irregular lines. Review of the 02/06/2026 written statement from the previous Administrator revealed she noted she had ordered a large amount of clothing for the resident because he needed a spend down from his account. She ordered clothing in different sizes for him after asking if she could get him a new wardrobe, to which he agreed. She noted a large number of outfits arrived at the facility and he did not like them. She further noted she had known the resident for many years and felt she had a personal relationship with him that allowed her to do that. She also noted she did not tell him the exact amount of money in his account because he did not make good decisions regarding his money and would allow other residents-especially women-to manipulate him out of money. She further noted she had accidentally ordered the wrong sizes and had not sent the clothing back because she had not thought about it. Review of the Resident Statement Landscape form revealed that on 11/03/2025 the resident had a balance of \$101,194; on 12/01/2025 the balance was \$89,711; on 01/02/2026 the balance was \$90,137; and on 02/02/2026 the balance was \$88,742. Interview with the Interim Administrator and the Human Resources employee on 04/20/2026 at 10:55 AM, they stated the resident could not sign his name and was only able to make an X with very irregular lines. They both stated the resident would not be able to make a perfect X. They stated that when the clothing arrived, the resident did not like it, but the company would not refund the money. They stated the facility ended up reimbursing the resident. Interview with the Regional Operations Manager on 04/20/2026 at 11:06 AM, she stated LPN A called her on 02/04/2026 and reported she saw something suspicious on the copy machine regarding R11. LPN A reported the resident could not make a clear X for his mark/signature. She then reported it to the previous Administrator, corporate, and the corporate Resident Fund Management Service. The Regional [NAME] President then conducted the investigation in the facility.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review, staff interviews, and review of the policy titled Freedom of Abuse, Abuse Prevention: Fast Alerts, the facility failed to protect one of 18 sampled residents(R) (R10) from misappropriation of funds by not reporting to the state agency and law enforcement. Findings include: Review of the facility policy titled Freedom of Abuse, Abuse Prevention: Fast Alerts documented Reporting/Investigation/Response Policy - Any complaint, allegation, observation, or suspicion of resident abuse, mistreatment, or neglect-whether physical, verbal, mental, or sexual, involuntary or voluntary-was to be communicated to the Abuse Coordinator, thoroughly reported, investigated, and documented in a uniform manner as detailed below. Reporting. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than two hours after the allegation was made if the events involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events did not involve abuse and did not result in serious bodily injury. Review of the 02/06/2026 Facility Incident Report Form revealed the facility reported an allegation of Exploitation/Misappropriation of Resident Property/Funds for R10. The report indicated the resident did not authorize an online purchase for clothing on 11/25/2025. Review of the facility investigation revealed no evidence the Sheriff's Department was notified. Interview on 04/21/2026 at 9:00 AM with the Interim Administrator revealed he called and spoke to an investigator with the Sheriff's Department, who told him there was no report found for the 02/06/2026 allegation. Review of an email correspondence dated 02/10/2026 revealed the previous [NAME] President of Operations had asked if the police had been by and was told no. However, there was no evidence that staff followed up with the Sheriff's Department. Interview on 04/21/2026 at 9:00 AM with the Interim Administrator revealed staff should have made a follow up call to the Sheriff's Department.</p>		